Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

RYAN POTTER MD
5734 SPOHN DRIVE
CORPUS CHRISTI TEXAS 78414

Respondent Name
CITY OF CORPUS CHRISTI

Carrier's Austin Representative Box
Box Number 29

MFDR Tracking Number
M4-07-2574-01

MFDR Date Received
December 8, 2006

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary taken from the table of disputed services: "Preauthorization was obtained prior to services being rendered. According to TWCC Fast Facts, if pre-approval was obtained for a compensable injury, approval guarantees payment. Per Medicare's reimbursement guidelines, injectables are separately reimbursable (Medicare carrier manual part 3 (Chap 11)(Sec 2049)."

Amount in Dispute: $727.55

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier did not submit a response to the DWC060 request.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 8, 2006	64483, 64484, 76005, J1040, J3010, J2250, J3490	$727.55	$725.22

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute resolution for which the dispute resolution request was filed on or after January 15, 2007.
2. 28 Texas Administrative Code §134.202 sets out the fee guideline for professional medical services provided on or after September 1, 2002.
3. 28 Texas Administrative Code §134.600, sets out the preauthorization guidelines.
4. Division rule at 28 TAC §134.1, effective May 16, 2002, requires that services not identified in a fee guideline shall be reimbursed at fair and reasonable rates.

5. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated May 4, 2006
   - 62 – Payment denied/reduced for absence of, or exceeded, pre-certification/authorization

Issues

1. Did the requestor obtain preauthorization for the disputed charges?
2. Did the requestor bill for bundled codes?
3. Did the requestor submit documentation to support fair and reasonable reimbursement for the unvalued codes?
4. Did the requestor submit documentation to support the billing of HCPCS codes 64483, 64484, 76005, J1040, J3010 and J2250?
5. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.600, preauthorization was obtained from FARA Healthcare Management. Review of the preauthorization letter dated March 3, 2006 revealed that the requestor obtained preauthorization for Outpatient Repeat Left L5, S1, Two Level Transforminal Epidural Steroid Injection. Preauthorization was approved under preauthorization # FHD702624B. The requestor rendered and billed for an Outpatient Repeat Left L5, S1, Two Level Transforminal Epidural Steroid Injection. Therefore, the MDR section has jurisdiction to review the disputed fee dispute.
2. Per 28 Texas Administrative Code §134.202 "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section." CCI edits were run to determine if edit conflicts exists for date of service March 8, 2006. Review of the CCI edits finds:
   - No CCI edit conflicts were identified.
3. Per 28 Texas Administrative Code §134.202 "(c) To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: (1) for service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by CMS multiplied by 125%. For Anesthesiology services, the same conversion factor shall be used. (2) for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L: (A) 125% of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule. (B) if the code has no published Medicare rate, 125% of the published Texas Medicaid Fee Schedule Durable Medical Equipment/Medical Supplies Report J, for HCPCS; or (C) if neither paragraph (2)(A) nor (2)(B) of this section apply, then as calculated according to paragraph (6) of this subsection.
   - HCPCS code J3490 is defined as an "Unclassified drugs."
   - Review of the Medicare Fee and Texas Medicaid fee schedules did not contain an assigned value for HCPC code J3490; therefore reimbursement is subject to Rule 134.1.

   Per 28 Texas Administrative Code §134.202 "(c) To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: (6) for products and services for which CMS or the commission does not establish a relative value unit and/or a payment amount the carrier shall assign a relative value, which may be based on nationally recognized published relative value studies, published commission medical dispute decisions, and values assigned for services involving similar work and resource commitments."

   Division rule at 28 TAC §134.1 requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."

   Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

Former 28 Texas Administrative Code §133.307(c)(2)(G), documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable; and." Review of the submitted documentation finds that:

- The requestor billed HCPCS code J3490 on March 8, 2006.
- The CPT code indicated above does not have a Medicare assigned value.
- Division rule at 28 TAC §134.1, effective May 16, 2002 requires that services not identified in a fee guideline shall be reimbursed at fair and reasonable rates.
- The requestor did not provide documentation to demonstrate how it determined its usual and customary charges for HCPCS code J3490 on March 8, 2006.
- Documentation of the comparison of charges to other carriers was not presented for review.
- Documentation of the amount of reimbursement received for these same or similar services was not presented for review.
- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.

The requestor did not support that the requested alternative reimbursement methodology would satisfy the requirements of 28 Texas Administrative Code §134.1.

4. Per 28 Texas Administrative Code §134.202 "(c) To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: (1) for service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by CMS multiplied by 125%... (2) for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L: (A) 125% of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule...." Review of the submitted documentation finds that:

   - The requestor billed and documented procedure codes 64483, 64484, 76005, J1040, J3010 and J2250.
   - The CMS-1500 identifies that the services were provided in an office setting (place of service code 11). Reimbursement is therefore recommended at the non-facility rate.
   - CPT Code 64483: The Medicare rate is $336.05 x 125% = MAR $420.06. This amount is recommended.
   - CPT code 64484: The Medicare rate is $161.70 x 125% = MAR $202.12. This amount is recommended.
   - CPT code 76005-WP, modifier WP was appended to identify that the requestor provided both the professional and technical component. The Medicare rate is $74.91 x 125% = MAR $93.63. This amount is recommended.
   - HCPC code J3010 x 2: The Medicare rate is $0.320 x 125% = MAR $0.40 x 2 units = $0.80. The requestor seeks $0.74, this amount is recommended.
   - HCPC code J1040: The Medicare rate is $9.267 x 125% = MAR $11.58. The requestor seeks $7.59, this amount is recommended.
   - HCPC code J2250 x 4: The Medicare rate is $0.217 x 125% = MAR $0.27 x 4 = $1.08. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $725.22.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $725.22 plus applicable accrued interest per 28 Texas Administrative Code §134.803 for dates of service prior to 5/2/06, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	March 19, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.